BRITISH JOURNAL OF HOSPITAL MEDICINE

CORE TRAINING FOR DOCTORS

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Walk the talk: how to efficiently present medical histories

Introduction

History-taking is a cost-effective and critical skill for all practising doctors. An equally important and perhaps underemphasized skill is the effective presentation of history findings. Well-delivered history presentations guide the use of diagnostics and help formulate therapeutic management plans. They also help define a context for clinical management. Presenting histories is among the most frequent tasks undertaken by trainee doctors. This could be in the setting of consultant ward rounds, handover meetings, obtaining specialist opinions or requesting investigations (Olaitan et al, 2010).

With the ongoing discovery of increasingly sensitive and specific markers for disease, one may question the relative use of medical histories, and whether too much of the clinician's time is invested in their presentation. When comparing the influence of medical histories to that of laboratory investigations on reaching a final diagnosis, Hampton et al (1975) found that nearly 50% (34 out of 80) of diagnoses from the referring clinician were amended after a new history was taken. After subsequent laboratory investigations were performed, the final diagnosis changed in less than 10% of cases.

These findings concurred with a study of similar design by Roshan and Rao (2000), in which 78% (77 out of 98) of patient diagnoses were correctly derived from the history, and only 13% of diagnoses required the use of investigations. Over decades, the medical interview has remained the most likely point at which an accurate diagnosis can be obtained, and is further evidence of the importance of accurate case presentations.

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There are many resources on the topics of taking medical histories and performing physical examinations, but there is scarce guidance for effectively communicating clinical findings. This article provides pointers to help quicken the learning curve during your early days of presenting.

How to approach the presentation

There are no 'right' or 'wrong' ways of presenting, but presentations can be delivered well or poorly, and there is always scope for improvement. Oral case presentations integrate and convey clinical information about a case to an audience who can facilitate continuity of care. It is natural for junior doctors to view history presentations as an exercise of meticulously conveying patient details, a task painstakingly governed by preformed headings, rules and order. This viewpoint fosters a comprehensive, systematic approach. However, there are no rules about how case presentations should be presented, structured and ordered. Experience and practise moulds a rigid technique into a flexible one that you eventually find easier and more effective. The key to making this transition is to consider the patient, purpose, audience and context of the presentation all together (Haber and Lingard, 2001; Olaitan et al, 2010) (*Figure 1*).

Understand the context

The foundation to delivering a coherent presentation lies in preparation. First, identify the context in which your presentation is to be given. Do you need to introduce the patient from the start, or update on progress? Are you presenting with a view to handing over care? Other reasons for presenting include requesting certain investigations or interventions, and obtaining specialist opinions. How recently has the patient been admitted? What aspects of the history are likely to be new and relevant for the listener? What urgent issues need addressing? Is the patient stable? If not, how quickly is he/she improving or deteriorating? What salient points from the history are likely to relate to the central problem? Asking yourself such questions helps to determine the relevant content to include in your presentation.

Do your homework

It is often helpful to verify or supplement history findings using the patient's notes or correspondence. Explore the results of relevant investigations and imaging studies, comparing with later or earlier versions to identify changes. If the patient has already received treatment or interventions, make a note of whether the outcomes were satisfactory. Consider contacting colleagues previously or currently involved in the patient's care to clarify aspects of the history. Try to understand what roles they have played in the overall management of the patient, mentioning these in the presentation if appropriate.

Tailor your approach to the patient

'Presenting complaint' is a misnomer at times, since it is not always the most recent or urgent clinical problem. New clinical problems can arise, overshadowing or compounding the original reason for admission. Patient management should be viewed as a flexible process that is being continually refined. Depending on when the patient is first encountered, the history presentation serves subtly different purposes.

New patients

For new patients, an effective history presentation guides the identification of what caused the presenting complaint. Highlighting key findings relevant to the presenting complaint is an effective way to introduce a new patient:

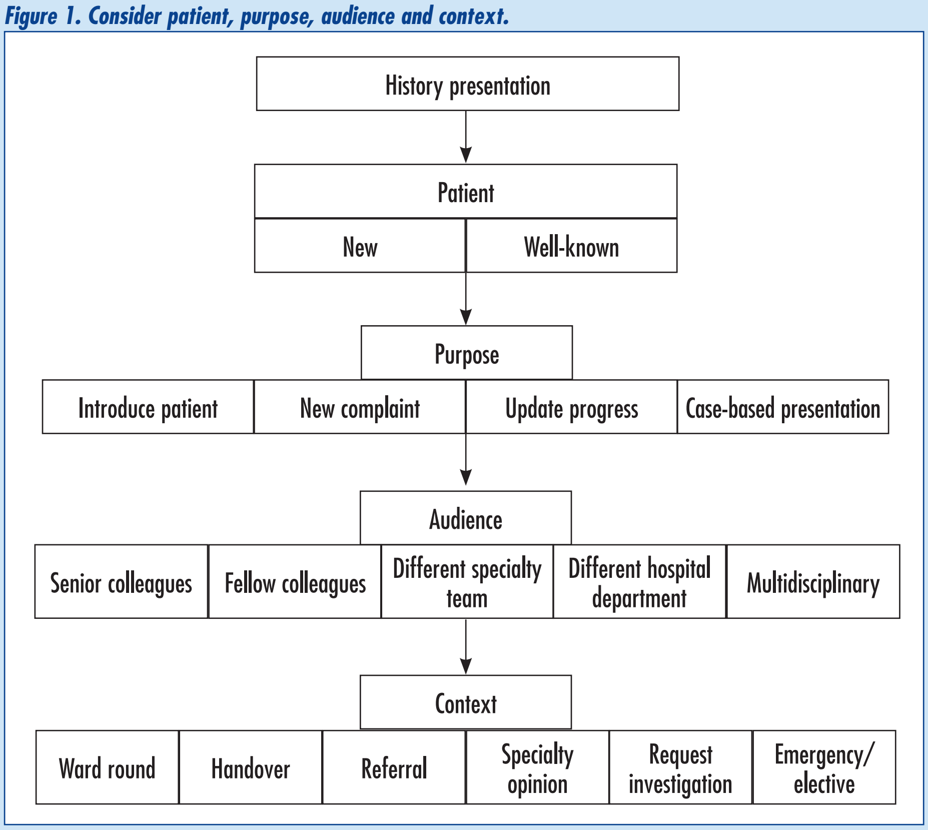
'Mr X is a 54-year-old office worker with known hypertension, diabetes and a 25 pack year smoking history presenting with chest pain and palpitations…'

Well-known patients

In well-known patients with repeated hospital attendances, the purpose of the presentation more commonly is to update on progress. In so doing, it defines a new baseline context, forming new aims and objectives for subsequent clinical management until the next encounter. State what has changed since the last encounter, whether management was implemented as planned and whether the outcomes were satisfactory. Is the patient's condition stable, improving, or worsening?

'Mrs Y, a 62-year-old lady with longstanding bilateral knee osteoporosis, continues to experience morning stiffness and knee pain. These symptoms have escalated in severity over the past month, despite maximal analgesic therapy in combination with frequent intra-articular corticosteroid injections in outpatients. She could climb two flights of stairs with moderate discomfort last month, but now struggles to walk even on the flat…'

Figure 1. Consider patient, purpose, audience and context.



Organize your findings

Remember, your findings need to be compiled into a coherent structure for the listener. This can be achieved using a history template (*Table 1*).

Any history template is best used as a fluid framework to help structure a case presentation. Integrating and discussing related themes collectively offers greater clarity than systematically discussing subcategories of a history template in isolation. Certain aspects of the template can be omitted entirely, while greater emphasis can be put on other areas.

Keep it relevant

The ability to decipher what is relevant to the current context and only present those aspects of the history is a difficult skill to impart and comes with practise (Green et al, 2005). The inclusion of irrelevant content is common among junior doctors,

Table 1. Example of a standard history template

Presenting complaint
History of presenting complaint
Past medical, surgical and interventional history
Drug history
Family history
Social history
Systems review

contributing to lengthened presentation times. This problem was demonstrated in one study, which found that junior doctors often confused relevance with the need to be thorough. In this study, Wiese et al (2002) argue that deciphering relevance from irrelevance during case presentations is a facet of clinical reasoning. Compared to students receiving standard ward instruction, those randomized to a programme of clinical reasoning achieved higher quality presentation scores and shorter presentation times. If similar correlations exist in junior doctors, a greater emphasis on clinical reasoning in curricula for doctors in training may improve the quality of case presentations by junior doctors.

Supervised peer-to-peer teaching and reflection on case presentations may be a promising method of exploring how junior doctors determine relevance. In Kathiresan and Patro's (2013) study, where junior doctors were asked to circulate vignettes with discussion probes before presenting teaching cases to peers, it was found that discussion did not always proceed in the direction intended by the presenter. Junior doctors found determining relevance a subjective concept, with some preferring to elaborate on different aspects of the case than others (Kathiresan and Patro, 2013).

Thinking back to your most recent case presentations, did the listener agree with what you regarded as relevant? What could you learn from any differences in opinion? Were you prompted to provide details of the case that you had not thought of, or to elaborate further than you had initially on an aspect of the history that you mentioned?

Differential diagnosis and reasoning

It is generally best to offer your differential diagnoses and a management plan at the end of the case presentation, rather than at an earlier point while you are still disclosing your findings. Although desirable, it is not important that your suggestions are correct. In the early stages of your career it is essential to practise justifying your differentials and management plan with pertinent aspects of the history. A good way to do this is to review key points from the history before offering your suggestions:

'In view of the sudden onset, sharp non-radiating chest pain, immobility and recent pelvic surgery, this is most likely to be a pulmonary embolism (PE). However, I would also keep in mind the possibility of a pneumothorax. I would recommend performing a full blood count, international normalised ratio (INR), D-dimer, chest X-ray, and computed tomography pulmonary angiogram (CTPA). If the investigations are suggestive of a PE, I would begin treatment with dalteparin, and replace with warfarin after a few days for a period of 6 months…'

Conclusions

Presenting histories is a universal skill for trainee doctors in all specialties; one of intuition supported by guiding principles. No single template can accommodate the effective presentation of all cases, but they can provide pointers for discussion. Having verified and supplemented the history where appropriate, effectively structuring and ordering the content is akin to telling a story that is interesting, relevant and unfolds in a logical sequence. Reviewing the key twists and turning points of the story, the presentation finally ends with your own insights and solutions before handing over to the audience. BJHM

Conflict of interest: none.

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KEY POINTS

- Consider the patient, context, audience and purpose of the presentation.
- Adopt a systematic approach before developing a more focused, flexible one.
- Include relevant content in your presentation.
- Supplement the presentation with findings from relevant investigations and outcomes from key interventions.
- Presenting a new patient differs from presenting a well-known patient.
- Discussing linked themes in unison rather than isolation offers greater clarity to the listener.
- Expect questions from the listener(s), clarifying what they would like to hear about if necessary.

TOP TIPS

- In non-urgent settings, take your time.
- Think before speaking.
- Be chronological.
- Practise with colleagues.
- Proactively ask for feedback.
- Analyse what went well in good presentations and what went wrong in bad presentations.
- Present in as many settings as you can (e.g. ward rounds, grand rounds, handover meetings, specialty referrals, requesting investigations).